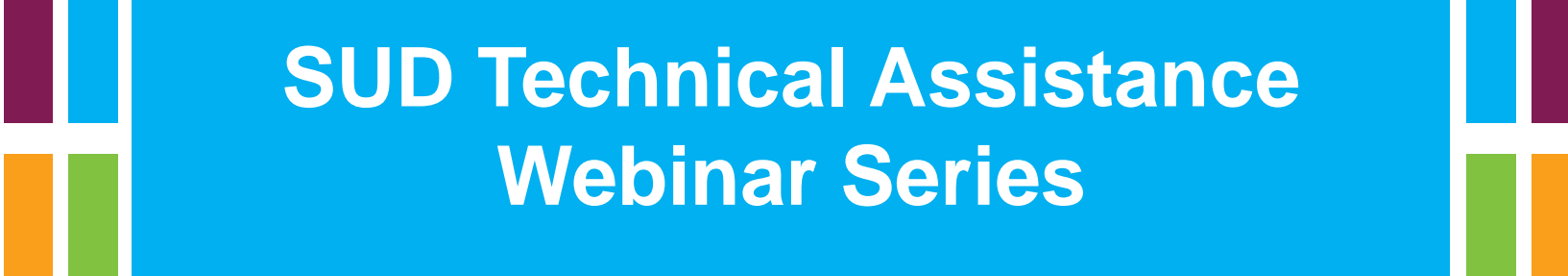




The Centers for Medicare and Medicaid Services:
SUPPORT Act Section 1003 Grant



SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 11— CO-OCCURRING DISORDERS

PAUL BRASLER, LCSW

JANUARY 19, 2021

Department of Medical Assistance Services

Welcome and Meeting Information

- WebEx participants are muted
 - Please use Q&A feature for questions
 - Please use chat feature for technical issues
- Focus of today's presentation is practice-based – please Contact SUD@dmass.virginia.gov with technical or billing questions
- SUPPORT 101 Webinar Series slide decks are available on the DMAS ARTS website – www.dmass.virginia.gov/#/ARTS
- We are unable to offer CEUs for this webinar series

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- **Last revision: January 11, 2021**

Disclaimer

The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$4,836,765 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven't already, before the start of today's webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey. <https://redcap.vcu.edu/surveys/?s=C8HERT9N3P>

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a \$50 Amazon gift card as well as participation in the post-webinar survey will enter you into another \$50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!

Naloxone Resources

- Get trained now on naloxone distribution
 - REVIVE! Online training provided by DBHDS every Wednesday
 - <http://dbhds.virginia.gov/behavioral-health/substance-abuse-services/revive/lay-rescuer-training>
 - <https://getnaloxonenow.org/>
 - Register and enter your zip code to access free online training
- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!
- Getting naloxone via mail
 - Contact the Chris Atwood Foundation
 - <https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422>
 - Available only to Virginia residents, intramuscular administration

Website Update



DMAS Home Page:

<https://www.dmas.virginia.gov/#/index>

ARTS Home Page:

<https://www.dmas.virginia.gov/#/arts>



SUPPORT Act Grant Website -

<https://www.dmas.virginia.gov/#/artssupport>

SUPPORT Act Grant Overview

The Virginia Department of Medical Assistance Services (DMAS) was awarded the Centers for Medicare & Medicaid Services SUPPORT Act Section 1003 Grant in September 2019. The purpose of this grant is to decrease substance use disorder (SUD) provider workforce barriers and increase the treatment capacity of providers participating under the state Medicaid program to provide SUD treatment or recovery services.

Grant Goals

- Learn from Addiction and Recovery Treatment Services (ARTS) program
- Decrease barriers to enter workforce
- Focus on specific subpopulations: justice-involved members and pregnant and parenting members
- Maintain our core values: person-centered, strengths-based, recovery-oriented

Grant Components

- Needs assessment
- Strengths-based assessment
- Activities to increase provider capacity

Period of Performance

September 2019 - September 2021

Grant Email

SUPPORTgrant@dmas.virginia.gov

Information

- Virginia Medicaid Agency Awarded Federal Grant to Combat Opioid Crisis [pdf]
- Summary of Virginia's SUPPORT Act Goals and Activities [pdf]
- Accessibility Notice [pdf]

Resources

- UCSF National Clinician Consultation Center Warmline [pdf]
- COVID-19 Resource Library [pdf]

Monthly Stakeholder Meetings

- October 2020 [pdf]
- September 2020 [pdf]
- August 2020 [pdf]
- July 2020 [pdf]
- June 2020 [pdf]
- May 2020 [pdf]
- April 2020 [pdf]
- March 2020 [pdf]

Fall 2020 Webinars

- Video: How to Set Up a Preferred OBOT Webinar
- Slide Deck: How to Set Up a Preferred OBOT Webinar [pdf]
- Video: Hepatitis C Treatment Webinar
- Slide Deck: Hepatitis C Treatment Webinar [pdf]
- Fall 2020 Webinar Schedule [pdf]

SUPPORT 101 Webinars

- Session Twenty: "Novel" Substances [pdf]
- Session Nineteen: SUD & LGBTQ+ Clients [pdf]
- Session Eighteen: SUD & Legally-Involved Clients [pdf]
- Session Seventeen: Alcohol & Cannabis [pdf]
- Session Sixteen: SUD and The Family [pdf]
- Session Fifteen: SUD & Cultural Humility [pdf]
- Session Fourteen: Addressing SUD Stigma and Building Provider Empathy [pdf]
- Session Thirteen: Group Therapy Skills [pdf]
- Session Twelve: Individual Therapy Skills [pdf]
- Session Eleven: Co-Occurring Disorders [pdf]
- Session Ten: Screening and Assessment for SUD [pdf]
- Session Nine: SUD Treatment Introduction [pdf]
- Session Eight: Opioids and Stimulants Overview [pdf]
- Session Seven: Substance Use Disorders (SUD) Overview [pdf]
- Session Six: Providing Trauma-Informed Care [pdf]
- Session Five: Withdrawal Syndromes [pdf]
- Session Four: Crisis and Deescalation [pdf]
- Session Three: Suicide Assessment and Screening [pdf]
- Session Two: Client Engagement [pdf]
- Session One: Tele-Behavioral Health in the time of COVID-19 [pdf]
- Dr. Mishka Terplan - Pregnant and Postpartum Care for SUD during COVID-19 [pdf]
- Dr. Mishka Terplan - HIV and HCV Updates [pdf]
- Dr. Mishka Terplan - Chronic Pain and Addiction Treatment [pdf]

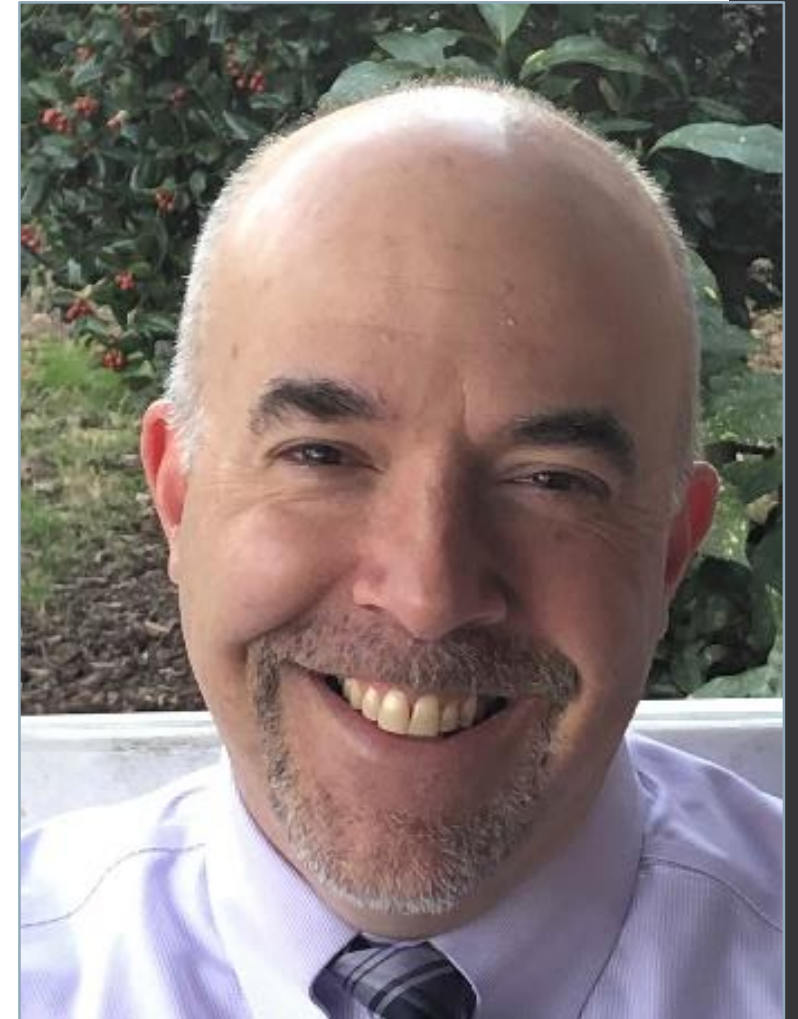
Hamilton Relay Transcriber (CC)

- The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.
- We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.
- The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.

Today's Presenter

Paul Brasler, MA, MSW, LCSW
Behavioral Health Addiction Specialist, DMAS

Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.



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ARTS Billing Questions

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An initial/provisional diagnosis is usually made following the end of a full assessment



This provides a “road map” for selecting initial treatment interventions and developing a more comprehensive/long-term treatment plan



An accurate diagnosis is a **dynamic**, not static, process that usually proceeds through a process of elimination



The diagnosis guides, but does not dictate, treatment

Diagnosis Formulation

Diagnosis: Exclusionary Factors

When making a diagnosis, you must take the following into account:

- The symptoms **must** cause a significant disturbance in the individual's life over a stated minimal timeframe that is specific to the diagnosis, (i.e., two weeks, six months, etc.)
- The disturbance **must** impact several of the patient's life domains unless otherwise specified
- The disorder **cannot** be the result of a **medical condition**
- The disorder **cannot** be the result of a **substance of misuse or a medication**

BASICALLY, FOLLOW WHAT IS IN THE DSM-5™

Substance-Induced Mental Disorders

- Alcohol-induced Depressive Disorder:
 - Alcohol-Induced Anxiety Disorder
 - Alcohol-Induced Bipolar Disorder
 - Alcohol-Induced Psychotic Disorder
 - Alcohol-Induced Neurocognitive Disorder (Dementia)
 - Alcohol-Induced Delirium
 - Alcohol-Induced Sleep Disorder
 - Alcohol-Induced Sexual Dysfunction
- Cannabis-Induced...
- Opioid-Induced...
- Stimulant-Induced...
- Hallucinogenic-Induced...
- Inhalant-Induced...

- Over half the people (a low estimate in my opinion) with a serious mental illness also have a serious substance use problem
- **Co-occurring disorders** (which used to be called Dual Diagnosis) are defined as the existence of at least one independent major mental disorder and one independent SUD
- Since most mental illnesses and SUD symptoms are identical, it is often difficult to determine if the symptoms are because of a mental illness or the effects of a drug

Co-Occurring Disorders

The following is a partial list of mental health disorders than can co-occur with substance use disorder:

- Schizophrenia
- Bipolar Disorders
- Major Depressive Disorder
- Anxiety Disorders
- Posttraumatic Stress Disorder
- Eating Disorders
- Personality Disorders (Cluster B)

Co-
Occurring
Disorders



“Individuals should be engaged in treatment that addresses their co-occurring psychiatric symptoms, even if the origin of the co-occurring mental disorder is unclear”

(SAMHSA, 2020, p. 126)

An aerial photograph of a complex, winding river system. The water is a deep blue, and the surrounding land is a rich, textured reddish-brown. The river meanders through the landscape, creating a series of interconnected loops and channels. The overall pattern is intricate and organic, resembling a map of a river delta or a complex network of waterways.

Schizophrenia

Schizophrenia: An Overview

- Schizophrenia is one of the most variable mental health disorders
 - Its symptoms overlap many other disorders, and none of the symptoms that define schizophrenia are specific to schizophrenia alone—they occur with many other disorders as well
 - At the same time, two people can have schizophrenia with completely different symptom-sets
- Despite older views that schizophrenia only starts in late adolescence or early adulthood, more contemporary views agree that schizophrenia can occur any time during and after adolescence
- “About 50% of clients with schizophrenia abuse substances; 75% have tobacco use disorder” (Herron & Brennan, 2015, p. 505)



Delusions



Hallucinations



Disorganized Thinking or
Speech



Grossly Disorganized
Behaviors



Negative Symptoms

Schizophrenia Symptom Groups

Delusions

- **Fixed false beliefs** that involve a misinterpretation of perceptions or experiences
- May involve a variety of themes, with persecutory being the most common
- **Ideas of reference** are also common, in which the person believes that certain gestures, television shows, song lyrics or environmental cues are specifically for them
- ***Bizarre*** delusions are clearly implausible
- “The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity” (APA, 2013, p. 87)

Hallucinations

- Occur with any sense, but the most common with organic psychotic disorders are **auditory hallucinations**
- Not under voluntary control
- Usually experienced as voices that are distinctly outside of the person's thoughts
- Certain types of auditory hallucinations, especially command hallucinations or voices making a running commentary on the person's thoughts or actions, are indicative of schizophrenia
- Not all strange perceptual experiences are psychotic
 - Illusions are misconceptions of actual sensory stimuli—these happen all the time
- Hallucinations are generated in the brain in the absence of any external stimuli

Disorganized Thinking/Speech

- The person may move from one topic to another (tangential thinking, loose associations)
- Answers to questions may be partially or completely unrelated to the question
- May be so severe that the person does not make any sense at all (word salad)



Grossly Disorganized Behavior

- A variety of behaviors from childlike actions to unpredictable agitation
- Problems may be noted in any goal-directed behavior, leading to problems with performing activities of daily living (e.g., maintaining hygiene)
- The person may appear to be disheveled, dressed inappropriately for the weather, or act bizarre



Negative Symptoms

Affective flattening: The person's face appears flat and unmoving, with poor eye contact and body language

Alogia: Brief, empty replies, decreased productivity of speech

Avolition: The person may sit for long periods of time, showing little interest in work or social activities



Schizophrenia: Development & Course

- Psychotic symptoms typically emerge between late teens and early 30's
 - Onset before adolescence is extremely rare
 - Later-onset cases are more likely to be female
- There is usually a slow and gradual onset of symptoms
 - Depression is often present
 - Some cognitive impairment may also be present
- Effective, sustainable treatment options remain limited
 - Some people can improve, but the majority require some level of assistance
- We are still unable to determine what specifically causes schizophrenia

Substances That Can Mimic Psychotic Disorders

- Stimulants (some more than others) at either regular levels or overdose
- Anabolic steroids
- Inhalants
- Cannabis (in some individuals); synthetic cannabinoids are more likely to cause psychosis
- Hallucinogens, Dissociates, Entactogens
- Alcohol: Wernicke-Korsakoff syndrome
- Depressant withdrawal syndrome

Treating Co-Occurring SUD & Schizophrenia

- Case management (or care coordination) is important to ensure that services are delivered consistently (especially when provided by separate agencies) to ensure treatment continuity
- Medication adherence is often necessary for people with psychotic disorders
- Some programs have case managers who visit clients daily to ensure they are safe, have enough to eat, are taking their medication, assess transportation needs, etc.
- Even outside such intensive services, CM can help with housing issues, along with food resources, medical concerns
- It is important to help the client create structure (e.g., a daily routine/structure) while also protecting the client's rights

Mood Disorders: Major Depressive & Bipolar Disorders



Major Depressive Disorder

Diagnostic Features

- Can present with either increased or decreased appetite, and increased or decreased sleep
- Increased agitation and anger outbursts are not uncommon
- Sense of worthlessness or guilt is often present
- Individuals may misinterpret normal daily incidents as evidence to support their negative self-concept
- Difficulty concentrating and/or making even simple decisions is a common symptom
- Thoughts of death and suicidal ideation are common

Major Depressive Disorder

Diagnostic Features

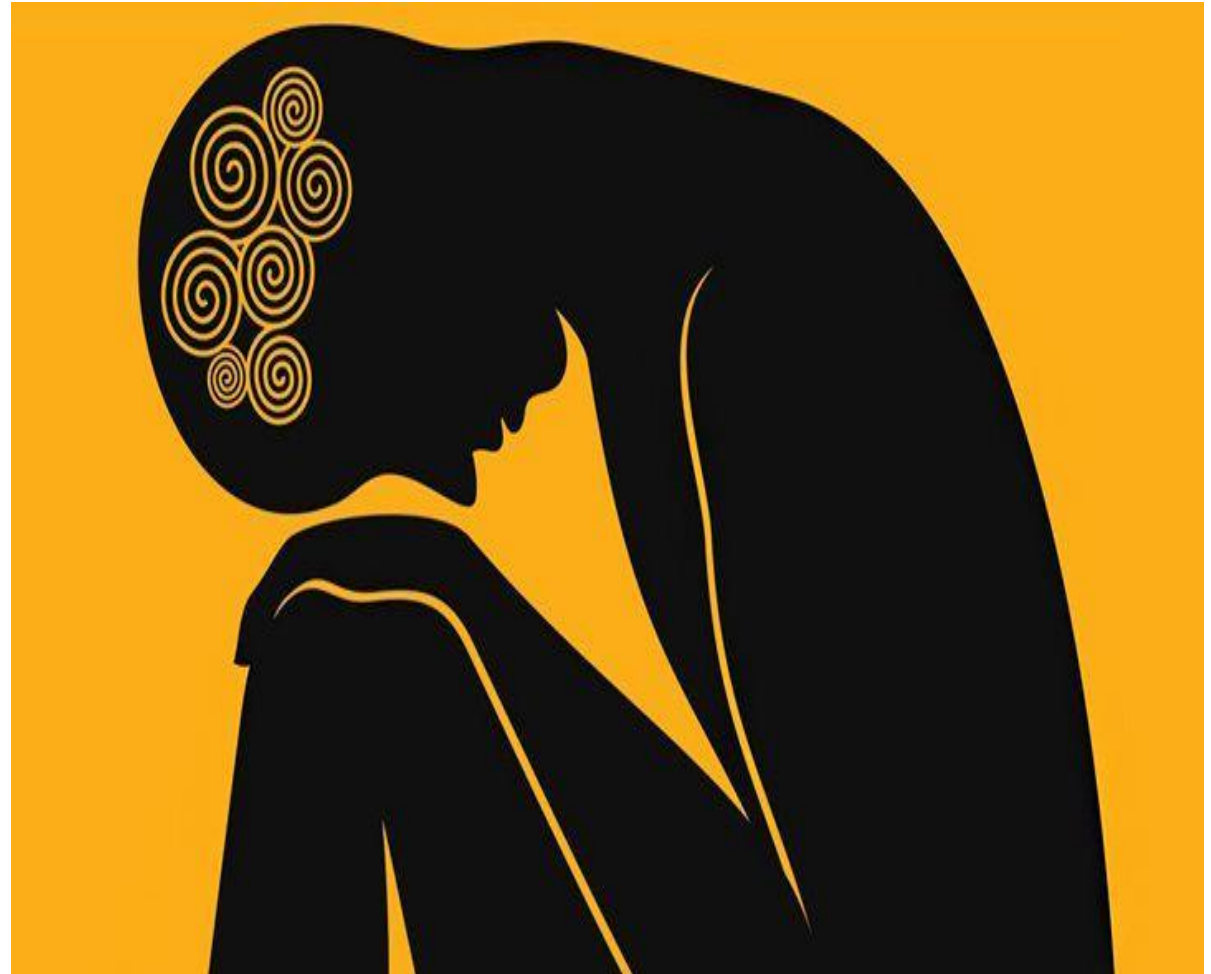
- Affective symptoms include tearfulness, irritability, brooding
- Excessive worry, even anxiety can be common
- Phobias, somatic complaints, and chronic pain symptoms can also occur
- Suicide is one of the possible mortality outcomes of depression (about 10%)
 - Untreated depression, even if it does not result in suicide, leads to higher mortality due to medical illness
- Fatigue or insomnia are usually presenting symptoms
- For some people with mild depression, they may appear to be functioning normally but doing so causes them to expend a lot of energy

Major Depressive Disorder: Prevalence, Development & Course

- 7% of people in the US suffer a Major depressive disorder each year (2 – 3% of children experience a MDD)
- Females are diagnosed with depression twice as much as males
- However, studies note no gender differences in phenomenology, course or treatment response
- Likelihood of onset is with or after puberty
- Variable course, and variable severity among individuals
- Many bipolar disorders begin with a depressive episode
- Depression increases in frequency with age

Substances That Can Mimic Depressive Disorders

- Chronic or excessive alcohol use, including alcohol intoxication and withdrawal syndromes
- Stimulant withdrawal
- Cannabis withdrawal
- Resolution phase of entactogens and hallucinogens



Bipolar I Diagnostic Features (Manic Episode)

- An abnormally, persistently elevated, expansive or irritable mood and persistently increased activity and energy that is present for most of the day, nearly every day, for a period of at least one week
- Mood is often described as “feeling on top of the world,” or “feeling high without drugs”
- Rapid shifts in mood may occur (happy, sad, angry, repeat...)—this is called lability
- May engage in multiple, overlapping projects, generally using goal-directed behaviors
- Inflated self-confidence to supreme grandiosity can occur

Bipolar I Diagnostic Features (Manic Episode)

- Engaging in risky or dangerous behaviors may be present
- Decreased need for sleep is a major indicator
- Speech is often loud and pressured—another person cannot get a word in edgewise
 - The speech itself may make no sense, and include singing; lots of drama
- If the person is irritable, their speech is often hostile, threatening and abusive, leading people close to the patient saying, “this is not at all like him; he never says things like that”
- Racing thoughts are often present

- Following the end of a manic episode, the patient may transition into a hypomanic episode, a depressive episode, or may return to a sense of normalcy (euthymia)
- Many people go from mania to severe depression
- The use of substances can co-occur with Bipolar I disorder, and the clinician needs to be careful to not label the effects of a stimulant or another inebriant as a manic episode
- Individuals experiencing a full-blown manic episode often require hospitalization for stabilization

Bipolar I Diagnostic Features

Bipolar I: Prevalence, Development & Course

- Roughly 0.6% of the US population meets criteria for Bipolar disorder each year
- Mean age of onset is 18 years of age
- More than 90% of people who have a single manic episode will go on to experience another mood episode
- Individuals with Bipolar I disorder who have four or more mood episodes in a single year (separated by periods of remission) are referred to as “rapid cycling”
- 10 – 15% of people with Bipolar I complete suicide



Stimulants (any kind)



Cannabis (in some individuals)



Hallucinogens



Dissociates



Depressant paradoxical stimulant
reactions in some individuals

Substances
That Can
Mimic a
Manic
Episode/
Bipolar
Disorder

Treating Co-Occurring SUD & Mood Disorders

- Current practice is to treat the SUD and then evaluate mood disorder symptoms when the client is not intoxicated or in acute withdrawal
 - If the symptoms persist beyond acute withdrawal, then evaluate for possible medical treatment of the mood disorder
- Psychotherapy (group and/or individual), in addition to appropriate medication therapy, is often the most helpful
- Case management can help clients determine what additional needs they may have and help the client connect with resources
- Help the client navigate peer groups that have outdated or biased views against the use of medication and treatment to address mood disorder symptoms

Anxiety Disorders: Overview

- The disorders in this group constitute many of the common complaints that bring people to counseling
- **Fear:** Emotional response to a real or perceived threat
- **Anxiety:** Response/anticipation of future threat
- These feelings can lead to pervasive avoidance behaviors that also cause problems in everyday functioning
- These disorders differ from typical fear, anxiety and avoidance in that they are **excessive** and **persistent**
- Many of these disorders develop in childhood and tend to persist if not treated

Panic Disorder: Diagnostic Features

- Panic attacks are abrupt and intense, with the symptoms often described as like a heart attack
 - Many of the accompanying or secondary symptoms are due to decreased oxygenated blood because the person has hyperventilated during the panic attack
- Panic attacks are often unexpected, with no obvious triggers
- Expected panic attacks often occur because the person is triggered by cues from a previous panic attack
- Frequency and severity can vary
- Many people with panic attacks worry that their symptoms are signs of serious underlying medical problems

Generalized Anxiety Disorder: Diagnostic Features

- Excessive worry and anxiety about nearly **everything** and nothing seems to alleviate the anxiety
- Females are twice as likely as males to experience symptoms
- People with GAD often develop depressive disorders
- Prevalence peaks at middle age, then declines
- I highly recommend that this diagnosis be used rarely, reserved for people who exhibit nearly all the symptoms for over six months and who are truly disabled by anxiety
- In children, GAD may manifest as a performance anxiety

Post Traumatic Stress Disorder & Acute Stress Disorder: Diagnostic Features

- The primary difference between PTSD and ASD is the length of time in which symptoms are present
 - ASD can be diagnosed 3 – 30 days following a traumatic event
 - PTSD can be diagnosed 30 days or more from the traumatic event
- **Most people who experience a trauma will not develop either ASD or PTSD**
 - Likewise, many people who are diagnosed with ASD do not progress to PTSD
- As we saw in the first section, the connection between trauma and SUD is substantial

PTSD & ASD Diagnostic Features

(SAMHSA, 2020, p. 86)

- **Intrusive, persistent re-experiences of the trauma**, including recurrent dreams or nightmares, flashbacks, and distressing memories
- **Persistent avoidance** of people, places, objects, and events that remind the person of the trauma or otherwise trigger distressing memories, thoughts, feelings, and physiological reactions
- **Negative alterations in cognitions and mood**, such as memory loss (particularly regarding details surrounding the event), self-blame, guilt, hopelessness, social withdrawal, and an inability to experience positive emotions
- **Marked alterations in arousal and reactivity**, such as experiencing sleeplessness or feeling “jumpy,” “on edge,” easily startled, irritable, angry, or unable to concentrate

Substances That Can Mimic Anxiety or trauma Disorders

- Stimulant use, overdose, or withdrawal
- Opioid Withdrawal
- Alcohol Withdrawal
- Benzodiazepine Withdrawal
- Panic during the use of hallucinogens, entactogens, or dissociates
- Adverse reactions to cannabinoids

Treating Co-Occurring SUD & Anxiety/Trauma Disorders

- “As a general rule, PTSD [and anxiety disorders] assessment should be conducted after a patient has emerged from acute alcohol or drug intoxication and withdrawal” (Herron & Brennan, 2015, p. 525)
- Group settings may be overwhelming to clients with anxiety and/or trauma disorders
- CBT approaches have proven successful in treating anxiety disorders and SUD
- Medical approaches should address potential abuse of medications, particularly benzodiazepines and drug-drug interactions

Treating Co-Occurring SUD & Anxiety/Trauma Disorders

- In the case of trauma-related disorders, trauma-informed care is essential throughout all phases of treatment
- Traumatic memories are often a trigger for the client to use, so establishing safety is imperative...
- ...but trauma and SUD can be treated concurrently
- One option is Seeking Safety: “A 25-session, present-focused, manualized treatment that provides psychoeducation, teaches coping skills, and helps clients gain more control over their lives” (Herron & Brennan, 2015, p. 527)

2021



Eating Disorders

- Eating disorders, particularly Anorexia Nervosa and Bulimia Nervosa, are some of the most serious mental health disorders
 - Mortality amongst individuals with these disorders is higher than nearly all other mental health disorders
 - This includes a higher risk of suicide
- Clinicians should not treat an individual with an eating disorder unless they have received professional training in treating people with Eating Disorders AND they are working as part of an interdisciplinary team that includes (at the very least) a medical provider trained in treating people with Eating Disorders and a Registered Dietician

Anorexia Nervosa Diagnostic Features

- “Individuals with anorexia nervosa (AN) are characterized by extremely low body weight for their age and height and are often adamant in their denial of the disorder” (Herron & Brennan, 2015, p. 529)
 - The person’s fear of gaining weight is profound, even when the individual is critically underweight
- There are two sub-types of AN:
 - Binge-Eating/Purging Type: “The weight loss and body image distortions are accompanied by binge eating and purging (vomiting, laxatives, etc.)” (Frances, 2013, p. 145)
 - Restricting Type: Very little energy is consumed
- Elevated suicide risk along with potential medical problems (e.g., emaciation, arrhythmias, hypotension, dehydration, loss of bone mass, growth retardation) are primary concerns

Bulimia Nervosa Diagnostic Features

- Individuals with BN are typically within the normal weight to overweight BMI range
- Excessive concern for body weight, shape and size
- Binging and compensatory behaviors are key components of BN:
 - “Binges are periodic, concentrated, and extraordinary ‘pig-outs’” (Frances, 2013, p. 147)
 - Purging is one subtype of BN, with vomiting the most common way of purging (enemas, laxatives and diuretics are also used)
 - Non-purging behaviors include excessive exercise and fasting
- A higher prevalence of BN than AN in the general population
 - Greater co-morbidity with SUD and BN (Gregorowski et al., 2013)
 - People can vacillate between AN and BN (Frances, 2013)

“Patients with eating disorders who abuse substances demonstrate worse ED symptomatology and poorer outcomes than those with EDs alone, and the presence of an ED in SUD patients leads to greater severity of substance abuse and poorer functional outcomes”

(Gregorowski et al., 2013, p. 7)

Eating Disorders & SUD

Treating Eating Disorders & SUD

- “The strongest message conveyed in current literature is the importance of screening and assessment for co-morbid SUDs and EDs in patients presenting with either disorder” (Gregorowski et al., 2013, p. 7)
 - The Eating Disorder Examination Questionnaire (EDE-Q 6.0) is a reliable screening tool (Berg et al., 2012)
- Concurrent treatment is highly recommended for co-occurring SUD and EDs (SAMHSA, 2020)
 - But given the lack of programs, SUD may need to be addressed first
- Clients with AN may require medical hospitalization to stabilize and treat medical issues related to their AN
 - This may include re-hydration and refeeding
- Individual and family therapies are often utilized for EDs & SUDs
 - CBT is often utilized as a treatment approach



Personality Disorders

Personality Disorders

- **Cluster A: Odd or Eccentric (Psychotic)**
 - Paranoid Personality Disorder
 - Schizoid Personality Disorder
 - Schizotypal Personality Disorder
- **Cluster B: Dramatic, Emotional or Erratic (Mood)**
 - Antisocial Personality Disorder
 - Borderline Personality Disorder
 - Histrionic Personality Disorder
 - Narcissistic Personality Disorder
- **Cluster C: Anxious or Fearful (Anxiety)**
 - Avoidant Personality Disorder
 - Dependent Personality Disorder
 - Obsessive-Compulsive Personality Disorder

Personality Disorders

- There is high comorbidity between Cluster B Personality Disorders, and low comorbidity with Cluster A and Cluster C PDs
 - Co-occurring SUD and Antisocial PD is more common in men
 - Co-Occurring SUD and Borderline PD is more common in women
- Cloninger (2000) focuses on four core features that are suggestive of any PD (as cited in Herron & Brennan, 2015, p. 520):
 - Low self-directedness
 - Low cooperativeness
 - Low affective stability
 - Low self-transcendence (unstable self-image, emptiness and erratic world view)

Borderline Personality Disorder Diagnostic Features

- Extreme impulsivity, including self-injurious behaviors that are typically not truly suicidal in nature
 - But because suicidal behaviors are common, death by suicide (sometimes accidental) is between eight and 10% of patients
- Easily bored
- Can be very rude, sarcastic, and demanding
- Typically undermine their own successes
- Symptoms tend to decrease in middle adulthood
- Difficult for many clinicians to develop empathy for people with BPD because of their unstable moods

Borderline Personality Disorder Diagnostic Features

- Diagnosed more often in women than men (3:1 ratio)
- The fear of abandonment is intense—a person with BPD finds being alone intolerable
 - “I hate you, don’t leave me; I love you, get away from me!”
- Dramatic, sudden and intense changes in how the person defines or expresses themselves
- People (including how the individual sees themselves) are seen in black and white, but they can change “sides” quickly
- Stability is elusive

Keys to Working with People with Borderline Personality Disorder

- Set limits at the beginning of treatment: This includes all outside-of-session contacts (unless this is a proscribed treatment modality like Dialectical Behavioral Therapy)
- You will likely be lavishly praised at the start of treatment; do not allow your ego to take control
- You will then be denigrated, often for no discernible reason; do not take it personally
- These individuals are usually in a state of perpetual crisis or near-crisis; you remain calm
- Likewise, their focus on their treatment will likely be all over the place: Set goals and objectives and stick with them; I recommend a CBT or DBT approach

Antisocial Personality Disorder: Diagnostic Features

- The key aspect with ASPD is a pervasive (some say complete) disregard for the rights of others and a pattern of violating said rights in numerous settings
- The person must have some of the symptoms of Conduct Disorder before the age of 15 (I often ask adults if they have ever been in jail or prison, and why they were incarcerated)
- Be especially aware of aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules

Antisocial Personality Disorder: Diagnostic Features

- The manipulation and deceitfulness always lead to personal gain
- The person does not appear to learn from the consequences of their previous choices
- The person with APD always seems to have an excuse: “I saw it, I wanted it, so I took it”
- The person can be rude, even abusive, or they can be extremely charming and disarming
- Total lack of empathy; often blames others for their shortcomings
- More common in males; may become less severe as the individual ages
- May be mis-applied to people with lower SES

Narcissistic Personality Disorder: Diagnostic Features

- People with NPD often assume that others feel the same way about themselves as they do
- They are entitled: Often insist on having “the top” doctor, teacher, etc. for them or their family
- Only form relationships with others who “measure up” and who can help them get “to the top”
- Oblivious to the hurtful things they can say
- Envious of others when they succeed
- Self-esteem is incredibly fragile
- Much more common in men

Keys to Working with People with Antisocial PD or Narcissistic PD

- If you directly challenge their “superiority,” they will usually quit treatment; instead, ask a lot questions
- It is okay to allow them to be the “expert...”
- ...But do not allow them to bully you
- Calmly set the expectations for treatment at the beginning, especially if you are working with a couple or a family—and stick to the limits you set
- Remember at the core is a person whose ego is fragile; when “cornered,” they will attack (usually verbally, rarely physically)
- Do not take anything personally
- The individual will usually blame others for their problems: I suggest a Motivational Interviewing approach

Treating SUD & Personality Disorders

- SUD treatment, both individual and group, is compatible with Dialectical Behavioral Therapy, which is designed to address Borderline Personality Disorder
- Peer-led recovery groups can also be beneficial
- Clients with PD can overwhelm therapeutic groups with their emotional flooding, so facilitators may need to be more active and directive in groups if this occurs
- Likewise, some people with PD can be overwhelming to you as a clinician, so be mindful of transference and counter-transference issues and seek supervision as needed

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